

# PPI and H2 BLOCKER REQUEST FORM

(MAP-012802, revised 03-03-04)

**FAX to 866-863-8803** (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

**MAIL** to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

Submitted by: ☐ Prescriber ☐ Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

NAME OF DRUG REQUESTED	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)

Yes No Unknown

☐ ☐ ☐ Is the request for brand name only (if generic is available)? If yes, prescriber must *handwrite Brand Necessary* & sign beside it:

☐ ☐ ☐ Has the requested drug been prior authorized previously?  
☐ ☐ ☐ Has endoscopy or an esophagram been done? Give date of exam & results: \_\_\_\_\_  
☐ ☐ ☐ For PPI requests: Is the request for initial or new treatment with a PPI?  
☐ ☐ ☐ For PPI requests: Has the recipient has been treated for more than 12 weeks with PPIs during the past 6 months?

**DIAGNOSIS** (Check one)

<input type="checkbox"/> Barrett's esophagitis	<input type="checkbox"/> Gastric ulcer, acute or recurring	<input type="checkbox"/> <i>Helicobacter pylori</i> eradication protocol
<input type="checkbox"/> Duodenal ulcer, acute or recurring	<input type="checkbox"/> GERD (Gastroesophageal reflux disease)	<input type="checkbox"/> NSAID gastropathy
<input type="checkbox"/> Esophageal stricture	<input type="checkbox"/> GERD grade III-IV, continuing symptomatic	<input type="checkbox"/> Schatzki's ring
<input type="checkbox"/> Gastric cancer, current or previous	<input type="checkbox"/> GERD, atypical with chronic laryngitis, hoarseness, or cough due to reflux	<input type="checkbox"/> Zollinger-Ellison syndrome
		<input type="checkbox"/> Other (specify) _____

PPI or H2 blocker Therapy (List all PPI's and H2 blockers used in the past 3 months.)	Dosage Form	Strength	Directions for Use	Date treatment started	Date treatment ended

**CURRENT MEDICATIONS** \_\_\_\_\_

**MEDICAL JUSTIFICATION** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

LEAVE THIS SECTION BLANK